Question and Answer Session – CY 2011 RADV Industry Training

In CMS' October 2, 2012 HPMS Memo announcing the October 9, 2012 MA Industry Training, we advised Medicare Advantage Plans that questions received 24 hours or more in advance of the training would be considered for inclusion in the Question and Answer session. The following questions and responses reflect the concerns that were received within the required timeframe.

Many questions were similar in nature and thus have been consolidated into one response. Please continue to send questions regarding the training session to radv@cms.hhs.gov.

Sampling

1) Q: The first question has to do with eligibility for sampling and the active status of the contract. The question was as follows: "By active contract, do you mean a contract active in CY 2011 or active at the time the selection is being made? Could a plan that terminates at the end of 2012 be selected for the CY2011 RADV audit?"

   A: By active contracts, we mean those contracts held by MA organizations having received risk adjusted payments for any given calendar year may be audited. Any plan that terminated at the end of 2012, but which was not acquired by or part of a merger with an active contract, would not be selected for CY2011 RADV audit by the Centers for Medicare Plan Payment Group. Note that a determination by MPPG to exclude MA contracts from the CY2011 RADV audit does not preclude any other federal agency from conducting its own audits of CY2011 payments to a MA contract.

2) Q: We received a few questions regarding eligibility for sampling- if there are any restrictions on contracts being sampled for two consecutive years in a row or multiple contracts from a parent organization being sampled concurrently or in subsequent years?

   A: Being selected one year for a RADV audit does not preclude that MA contract from being selected for future audits. There are no exclusions due to participation in multiple RADV samples at either the parent organization or contract level.

3) Q: We also received questions concerning the sampling criteria CMS uses, for example: "How does CMS select health plans for RADV audit?"

A: Selection of contracts for CY 2011 will be based primarily on coding intensity, i.e. the average change in the disease component of a contract's risk scores compared to the average change in FFS risk scores.

4) Q: Since this is training for CY2011 (dates of service 2010) RADV, does CMS expect to perform further RADV audits on prior payment years, or are those years' audits completed and the years effectively reconciled?

   A: The next contract level RADV audit will be conducted on diagnoses submitted for calendar year 2011 payments per *the February 24, 2012 Notice of Final Payment Error Calculation Methodology***.** *The RADV Pilot 07 and Targeted 07 samples are still active audits and have not been reconciled or completed.*

5) Q: Does RADV apply to 1876 cost plans?

   A: The 1876 cost plans are excluded from RADV because they do not receive risk adjusted payments.

Medical Record Review

6) Q: A few questioners had diagnosis and documentation specific issues, such as the following: "If the Health Plan was asked to validate uncomplicated Diabetes (DM) and was able to collect and provide one record that lists DM only in the Past Medical History section of the progress note, would CMS find this record acceptable to validate the DM HCC?"

   A: CMS is unable to respond specifically to individual questions regarding risk adjustment requests for interpretation of RADV coding and reporting questions as a full review of the documentation is required before reporting or coding any diagnosis. For the purposes of risk adjustment data validation, all review is considered on a case by cases basis due to multiple coding rules that may apply. Risk adjustment is based on the ICD-9 coding guidelines. We would encourage you to refer to resources regarding ICD-9 coding guidelines.

7) Q: The next question has to do with the RADV checklist that is posted on the CMS website. The questioner asks: "The disclaimer at the bottom of the document states, "(CMS) may determine the validity of medical record documentation based on criteria other than those described herein." Please share the criteria you will be using to determine the validity of the medical record."

A: We will provide RADV sample specific checklist guidance in the audit instructions for each specific audit. The version of the checklist currently posted on the website called the "Risk Adjustment Data Validation (RADV) Medical Record Checklist and Guidance" is meant to reflect CMS' general RADV guidance only.

8) Q: What CMS references should a plan use for guidance on acceptable electronic provider signatures?

A: CMS will provide guidance for this issue in the RADV audit specific instructions.

9) Q: CMS received several questions about the new multiple medical records per HCC policy and the abstraction process, such as the following: "Is there any limit to the number of records to validate a given HCC?" "Will CMS review all of the records to substantiate the HCC?"

A: CMS will allow audited MA organizations to submit up to five medical records per each audited CMS-HCC sampled per enrollee, beginning with the CY 2011 RADV audits. All diagnoses will be abstracted from the medical record ranked highest in priority by the submitting MA organization and which also supports the CMS-HCC under review. Additional guidance for MA organizations which have MA contracts selected for audit will be forthcoming in audit instructions.

10) Q: CMS received a question regarding submissions as follows: "What are the computer system requirements for submission of medical records?"

A: Again, additional guidance for MA organizations which have MA contracts selected for audit will be forthcoming in audit instructions and training for MA organizations.

Medical Record Dispute (MRD)

11) Q: Relating to MRD, what are the timeframes for submission of "one best medical record"?

A: MA organizations will be notified ahead of time by CMS regarding the estimated time-frames for medical record dispute for contracts selected for audit.

12) Q: How much time will the Plans be allowed during the Medical Record dispute process?

A: Additional guidance regarding time frames will be forthcoming in audit instructions for MA organizations which have MA contracts selected for audit, prior to the medical record dispute process.

Payment Recovery

13) Q: Will the recovery of dollars be done at the member level, or will recoveries be a lump sum recovery at the MA contract level? Also, will recoveries be reflected in revised MMR & MOR reports issued to the impacted MA contracts?

A: Recoveries based on extrapolation will begin with the calendar year 2011 RADV audits. MA organizations with audited contracts will receive a report after each stage of the RADV process that details the findings at the HCC level. It is not anticipated that these findings will be reflected in MMR or MOR. The recovery amounts will be provided in the plan payment letter.

14) Q: CMS received several questions relating to the FFS adjuster such as the following: "What is the amount?" "What is the method for calculation?" "What is the timeframe for release?"

A: *At this time, no additional guidance other than the training presentation materials is available. CMS will provide additional FFS adjuster guidance once it is available.*

Audit Timeframes

15) Q: CMS received several questions about the timeline such as follows: "When will the sampled contracts be notified?""When will results be available?"

A: *At this time, specific notification dates and specific timeframes for releasing results are not available. More information will be forthcoming in the specific audit instructions for MA contracts selected for audit.*